A TO Z MEDICAL EQUIPMENT & SUPPLIES

MEDICAL EQUIPMENT PRESCRIPTION

Please send completed form along with patient's face sheet.

PHONE: (214) 349 - 2869 | FAX: (214) 349 - 2871

☐ Revised **EMAIL: ORDERS@ATOZWHEELCHAIRS.COM**

REFERRAL INFORMATION

Facility _____ Patient _____ Height _____

Facility Contact _____ * DX ICD-10 _____ Weight _____

Order Confirmation: Text / Email _____ Discharge Date _____ **Sex** _____

Delivery Contact Cell Number _____ Patient DOB: ____ Address: _____

Primary Insurance: _____ ID # _____ Secondary Insurance: _____ ID# _____

PEDIATRIC MANUAL WHEELCHAIRS

- ☐ Folding Manual Wheelchair w/o Seating System (E1238)
- ☐ Folding Manual Wheelchair w/ Seating System (E1236)
- ☐ Rigid Manual Wheelchair w/o Seating System (E1237)
- ☐ Rigid Manual Wheelchair w Seating System (E1236)
- ☐ Tilt-in-Space Wheelchair w/o Seating System (E1233)
- ☐ Tilt-in-Space Wheelchair w/o Seating System (E1232)

- ☐ Elevating Leg Rests
- ☐ Height Adjustable Arms
- ☐ Reclining Back
- ☐ Seat belt
- ☐ Rear Anti- Tippers

- ☐ Standard Foot Rests
- ☐ Oxygen Holder
- ☐ Swing Away Arm Trough: ☐Rt ☐Lt
- ☐ Amputee Rest: ☐ Rt ☐ Lt ☐ Aka ☐ Bka

Cushions:

- ☐ Cushions Seat / Back*
- ☐ Adjustable Skin Protection Cushion / Back**
- ☐ Roho Cushion / Back**

*** Check Box For Both or Circle One** **** Patient must have at least history of a stage I sacral wound, Alzheimers, Parkinsons, Paralysis or Plegia to qualify.**

PEDIATRIC COMPLEX POWER MOBILITY DEVICES

- ☐ **K0835/K0836 Single Power - Group 2 *(Under 300 Lbs.)***
- ☐ **K0856/K0857 Single Power - Group 3 *(Under 300 Lbs.)***
- ☐ **K0858 HD Single Power - Group 3 (301 Lbs. - 450 Lbs.)**
- ☐ **K0861 Multiple Power - Group 3 *(Under 300 Lbs.)***
- ☐ **K0862 HD Multiple Power - Group 3 *(301 Lbs. - 450 Lbs.)***
- ☐ **K0863 VHD Multiple Power - Group 3 *(401 Lbs. - 600 Lbs.)***

- ☐ Pan Seat Option
- ☐ Oxygen Holder
- ☐ Swing Away Arm: ☐Rt ☐Lt
- ☐ Amputee Rest: ☐ Rt ☐ Lt ☐ Aka ☐ Bka

Cushions:

- ☐ Cushions Seat / Back*
- ☐ Adjustable Skin Protection Cushion / Back**
- ☐ Roho Cushion / Back**

Seat Width: ☐16″ ☐18″

Non Standard Width: ☐20″ ☐22″ ☐24″ ☐12″ ☐14″ ☐26″

Seat Depth: ☐16″ ☐18″

Hemi Height: ☐17″

*** Check Box For Both or Circle One** **** Patient must have at least history of a stage I sacral wound, Alzheimers, Parkinsons, Paralysis or Plegia to qualify.**

PEDIATRIC HOSPITAL BEDS

- ☐ **E0300 Pediatric Crib, Hospital Grade, Fully Enclosed**
- ☐ **E0328 Manual Pediatric Hospital Bed**
- ☐ **E0329 Semi-Electric Pediatric Hospital Bed**

- ☐ **Alternating Air Pressure Mattress**
- ☐ **Gel Overlay**
- ☐ **Patient Lift (Hoyer)**

Physician's Signature: _____ **Length of Need (1-99 Months)** _____

Ordering Physician: _____ **NPI** _____ **Date:** _____